



MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS A-10.0	Subject: INMATE DEATH	
Reference: NCCHC Standard P-A-10, 2014; 53-1-203 MCA, Powers and Duties of Department of Corrections; 46-4-122 MCA, Human Deaths Requiring Inquiry by Coroner; 50-22-101 MCA, Determination of Death, DOC 4.5.34 Offender Death	Page 1 of 3 plus two attachments	
Effective Date: November 1, 2010	Revised: June 1, 2017	
Signature / Title: /s/ Cindy Hiner / Health Services Manager		
Signature / Title: /s/ Tristan Kohut, D.O. / Medical Director		

I. PURPOSE

To establish reporting procedures to notify appropriate administrators, next of kin, and local authorities in the event of the death of an inmate.

II. DEFINITIONS

Death – When an individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem. A determination of death must be made by a physician or coroner.

Investigations Bureau – The office that oversees investigations for the Department.

Administrative Review – An assessment of correctional and emergency response actions surrounding an inmate's death in order to identify area where facility operations, policies and procedures can be improved.

Clinical mortality review – An assessment of the clinical care provided and the circumstances leading up to a death in order to identify areas of patient care or system policies and procedures that can be improved.

Psychological autopsy – A written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the individual's death. This is typically conducted by a psychologist or other qualified mental health professional.

III. PROCEDURE

A. Notifications

1. In the event of inmate death, the nurse or staff in charge must, as soon as possible, but no more than eight hours later, notify the facility health services administrator, the appropriate physician, and the Warden or designee.
2. In the event of inmate death, the Warden, or designee, must notify the Department medical director, the chief of the Investigations Bureau, and local law enforcement officials.
3. The Warden, or designee, will consult with the medical director and decide whether to request a post mortem examination. Unattended deaths and suicides require a post mortem examination.
4. The Warden or designee will immediately notify the Department Director by phone of any inmate death.

B. Progress Notes and Incident Reports

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1. Health care staff will complete progress notes as soon as possible, but no later than the end of the shift, citing witnessed facts concerning:
 - a. time of expiration;
 - b. nature of death;
 - c. circumstances surrounding nature of death at that time;
 - d. treatment rendered (if any);
 - e. persons notified of death; and
 - f. whether an autopsy was requested.
2. All staff who witnessed the death will complete incident reports as soon as possible, but no later than the end of the shift.

C. Release of Information

1. Employees must not release information concerning inmate death to outside media, e.g., newspapers, reporters, etc. Employees must refer all such questions to the Warden or MSP Public Information Officer.

D. Report of Inmate Death and Health Record

1. Within 24 hours, the MSP health services administrator, or designee, will complete and forward the report of inmate death and a copy of the inmate's health record to the Department Clinical Services Division Administrator, and the Department Investigations Bureau Chief.
2. The MSP health services administrator, or designee, will ensure that all health record entries are complete, all pages numbered, and that the original inmate health record is kept in a locked cabinet on-site.

E. Mortality Review

1. The Department Medical Director and/or the Clinical Services Division Administrator or designee will:
 - a. coordinate a multi-disciplinary mortality review that includes an administrative review, clinical mortality review, and a psychological autopsy review (if the death was by suicide). within 30 working days of an inmate's death (*see attachment*);
 - b. notify all the necessary disciplines involved, i.e., legal, medical, mental health, and custody staff, that the review will be conducted to:
 - 1) determine if there was a pattern of symptoms that may have precipitated an earlier diagnosis and intervention; and
 - 2) determine whether the events immediately surrounding the death show the appropriate interventions occurred.
 - c. When the medical autopsy is completed after the clinical mortality review has occurred, the review is appended with information from the autopsy report;
 - d. for expected deaths, a modified death review process, which focuses on the relevant clinical aspects of the death and preceding treatment, may be followed; and
 - e. once completed, the clinical mortality review and administrative review results are communicated to the unit health staff involved through the monthly Medical Review Panel.
2. Corrective action identified through the mortality review process is monitored and reviewed as needed through the facility CQI process. (see HS-A-06.0)

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3. The medical examiner or coroner will review all inmate deaths and subsequent reports.

IV. CLOSING

Questions concerning this operational procedure will be directed to the Health Services Manager.

V. ATTACHMENTS

MSP Mortality/Morbidity Review form
MSP Report of Inmate Death form

attachment A
attachment B

MSP MORTALITY/MORBIDITY REVIEW
Date

Personnel Present:

INMATE/PATIENT ID: _____

DATE & LOCATION OF DEATH: _____

CAUSE OF DEATH:

SUMMARY:

CORRECTIVE RECOMMENDATIONS:

Medical Director

Facility Health Services Administrator

Health Services Bureau Chief



DEATHS IN CUSTODY
MONTANA STATE PRISON INMATE DEATH REPORT

State: _____

1. What was the inmate's name?

Last First MI

2. On what date did the inmate die?

Month Day Year

3. What was the name and location of the correctional facility involved?

4. What was the inmate's date of birth?

Month Day Year

5. What was the inmate's sex?

Male 01 ☐ Female 02 ☐

6. What was the inmate's race/ethnic origin?

- 01 ☐ White (not of Hispanic origin)
02 ☐ Black or African American (not of Hispanic origin)
03 ☐ Hispanic or Latino
04 ☐ American Indian/Alaskan Native (not of Hispanic origin)
05 ☐ Asian (not of Hispanic origin)
06 ☐ Native Hawaiian or Other Pacific Islander (not of Hispanic origin)
07 ☐ Two or more races (not of Hispanic origin)
08 ☐ Additional categories in your information system—
Specify ☐

09 ☐ Not known

7. On what date had the inmate been admitted to one of your correctional facilities?

Month Day Year

8. For what offense(s) was the inmate being held?

- a. _____
b. _____
c. _____
d. _____
e. _____

9. Since admissions, did the inmate ever stay overnight in a mental health observation unit or an outside mental health facility?

- 01 ☐ Yes
02 ☐ No
03 ☐ Don't know

10. Where did the inmate die?

- 01 ☐ In general housing in the facility or on prison grounds
02 ☐ In segregation unit
03 ☐ In special medical unit/infirmery within your facility
04 ☐ In special mental health services unit within your facility
05 ☐ In medical center outside your facility
06 ☐ In mental health center outside your facility
07 ☐ While in transit
08 ☐ Elsewhere – Specify ☐

Name of deceased Inmate _____

11. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, post-mortem exam, or review of medical records) available in order to establish an official cause of death?

- 01 ☐ Yes – Complete items 12 through 16.
02 ☐ Evaluation complete, results are pending – Skip remaining items; you will be contacted later for those data.
03 ☐ No such evaluation is planned – Complete items 12 through 16.